Review Article

Palliative Medicine and Modern Cancer Care

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INTRODUCTION

Medical activity related to terminal care, care of dying, hospice care and end stage care is as old as medical practice itself, however, the palliative medicine as a specific entity dates from the mid-1980s. Over the last few decades, the subject of oncology has made significant advances. A better understanding of biology of tumour has resulted in new treatment strategies involving adjuvant and combined modality therapy. The addition of anthracycline and platinum based chemotherapeutic agents has helped turn previously devastating neoplasms like testicular tumours, small cell carcinoma of lung, and certain varieties of leukemia and lymphoma potentially curable, while the role of newer agents such as taxol and ifosfamide continues to be defined. The development of colony stimulating factors and improved techniques of bone marrow transplants have brought more aggressive programme for care of advanced cancers, with a better tolerance and compliance.

Despite these major advances reality is that a significant number of patients progress towards a fatal outcome detected in the advanced stage of their disease and barely understand and accept the outcome of cancer. For most of the people in every culture, cancer is still an illness with social and psychological ramification rather than a simple organ based disease. Unfortunately, for many oncologists and their patients even if evidence show that disease is on an irreversible course with no prospect for a reasonably successful outcome, a tendency still exists to treat the disease. Patients always remain hopeful that treatment will be successful despite the poor odds and physicians always avoid admitting the failure. Progress in the surgical oncological procedures has also made significant advances towards the aim to cure, however palliative surgery is still poorly defined and is in its infancy. Palliative radiotherapy is an important part of radiation oncology, yet it is discussed relatively infrequently at scientific meetings and also in literature.

There is a big challenge for oncologists and patients to recognize and accept an alternative approach. This approach should provide hope, allay fear, and allow patients to believe that they are not giving up something tangible by changing the focus from disease to patient. This is being done by addressing how the patients feel and by managing the patient's symptoms. By this alternative approach, the oncologist and patient can make a successful plan and can maintain hope of symptom relief and quality of life without undergoing battery of futile investigations.

Oncologist's Perception of Palliative Medicine

Although most cancer patients die of their disease, studies on the etiology and treatment of advanced stage symptoms have not yet received a high priority amongst oncologists of cancer centers. On an average each article in oncology journal provides an assessment of tumour response and drug toxicity but none of them reports the effect of chemotherapy on pain,

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which is one of the most prevailing symptom in the last stage of disease. Pain, dyspnea, fatigue, cachexia-anorexia are common symptoms with advanced cancer. However, besides pain, these symptoms are poorly understood and ineffectually treated.

Whenever a patient of metastatic cancer arrives, it is always difficult to decide whether he/she should be treated with palliative chemotherapy or should be given best supportive treatment.[1] Patient will always prefer treatment of the disease, however, clinician can inform a patient about the advantages and disadvantages of a certain therapy that can support the patient's decision-making process.[2] Over the years more modern concepts have developed in this regard.[3,4,5,6]

1. Medical oncology dealing with the skills and strategic coordination of oncological interventions from primary prevention to terminal phase should also include, assessment and treatment of patients subjective needs.
2. Anticancer therapy should be evaluated in terms of both quantitative and qualitative impact on patient's life.
3. Traditional view of palliative care intervention at an advanced stage of disease has to be modified: it must constitute a philosophical and methodological approach to be adopted from the early phase of illness itself.
4. The institution of total patients care should evolve into a practice that includes the oncologist and palliative care doctor together.
5. Relationship of an oncologist with palliative care physician should be one of cooperation rather than competition to ensure optimal patient care.
6. There should be knowledge based quality improvement programmes for oncologists, as far as end of life care is concerned.
7. Cancer care should optimize quality of life through the course of an illness by paying meticulous attention to the myriad physical, spiritual and psychosocial needs of the patients and family.

Therefore a Modern Cancer Center must recognize clearly that:

1. Primary physician is involved as Continuity of care is important. Patients should not be exposed to constantly changing groups of doctors and nurses. A specific physician-nursing team should be recognized by the patient and family as their primary support within the center. This is possible by a constant follow up of the patient and by interacting with palliative care team..
2. Pain and other symptoms can be assessed in a formal manner. Assessment dictates that we ask about the problems, When asked, patients and families will bring forward information which otherwise could be passed over in a busy clinic.[7] Current evidence suggest that oncologist may underestimate their patients pain and home family concern.[8,9]
3. Need for hospice care – the term means a comprehensive medically directed, team oriented program of care that seeks to treat and comfort terminally ill patients and their families at home or in a similar setting, establishing pain management and symptom control as clinical goals, understanding that psychological and spiritual suffering are as significant as physical pain. Hospice accepts death as a natural part of life and seeks to neither hasten nor prolong the dying process. Bereavement care is an integral part of hospice that is available to the family following the death of the patient.
4. Home care-The home should be the place of palliative care. The therapies should be designed to be suitable for home use. Palliative care has certain well established special techniques that allow, a previously hospital bound patient, to return home. For example use of pump delivered subcutaneous medication, epidural analgesia regimen, regular assessment and follow up by palliative care nurse at home.

CONCLUSION

In developed countries nearly 50% cancer patients approach hospitals in their advanced stage of disease, whereas, in India and other developing countries more than 80 % present in stages III and IV. Experiences from different cancer centers show that about two third of patients with cancer are incurable at presentation and are in need of immediate palliative care, therefore;

- It is the moral responsibility of oncologists that their cancer patients receive palliative care from the beginning if, necessary.
- In order to remove stigma associated with cancer, oncologist must openly discuss the diagnosis with patient and family.
- Oncologists must expand their role as assessor and manager of pain so as to make it possible for over 90% of oncology patients to have a pain free death at home.
- Oncologists have unique opportunity as clinical role models - to ensure proper management of patient's symptoms at diagnosis, during treatment and as death approaches.
- If fully implemented the integrated palliative care approach will result in quaternary prevention that is prevention of suffering.
- Hospice is the best-developed model for end of life care in the developed countries; however in developing countries like India home care is more cost effective which can ensure affordability and availability. There is a strength in Indian family structure to treat their patients with love and compassion; the cancer center in a highly populated country like India must learn to treat by remote control with the help of relatives. Out patients and home-based palliative care is ideal for India and many third world developing countries.
- Finally we should create a unique model of cancer care based on economy, culture and traditions rather than adopting other role models of developed countries.

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